STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS354AGC	A. BUILDING _____ B. WING _____	07/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACHELE SENIOR GUEST HOME	3398 BANCROFT CIRCLE LAS VEGAS, NV 89121

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Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 7/8/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, one Category I resident and five Category II residents. The census at the time of the survey was three. Three resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of C. The following deficiencies were identified:	Y 000	7/23/09 Acceptable POC Julie Bell	
Y 072 SS=E	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with	Y 072		

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Y 072	Continued From Page 1 satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This RULE: is not met as evidenced by: Based on record review on 7/8/09, the facility failed to ensure 1 of 3 caregivers had completed the required three hour medication management refresher training every three years (Employee #1). Severity: 2 Scope: 2	Y 072 ✓	Employee #1 registered for the medication training with Windy Simon on 7/23/09 Administrator is responsible that every employee must have the proper training in managing medications, will monitor every 3 months to be in compliance. P/s. see attached registration form on page 1.	7/17/09 7/20/09
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This RULE: is not met as evidenced by: Based on record review on 7/8/09, the facility failed to ensure 1 of 3 caregivers had background checks completed (Employee #1). Employee #1 does not have state or FBI background checks, and the fingerprints have not been submitted.	Y 105 ✓	Employee #1's background check was submitted to Dept. of Public Safety. P/s. see attached copies on pages 2 and 3. Administrator is responsible that background checks should be completed, on file and monitor every 6 months for compliance.	7/17/09 7/20/09

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Y 105	Continued From Page 2 Severity: 2 Scope: 2	Y 105		
Y 274 SS=C	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. This RULE: is not met as evidenced by: Based on observation and interview on 7/8/09, the facility failed to ensure menu substitutions were documented and retained for at least 90 days. The facility did not follow the scheduled menu for 1 of 2 meals observed today. Menus keep on file were not dated appropriately. Four menus were stapled together with the month written on the front. The menu on the fridge was dated July week one, however caregiver prepared lunch from week two. Breakfast was not the same as what was posted for either week. Severity: 1 Scope: 3	Y 274 ✓	Menu's was dated and posted. Substitutes and changes will be listed on the menu and also upon residents request. Administrator is responsible that menus are posted and dated and will monitor weekly to be in compliance	7/30/09 7/17/09
Y 878 SS=F	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in	Y 878		

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Y 878	Continued From Page 3 the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This RULE: is not met as evidenced by: Based on record review and interview on 7/8/09, the facility failed to ensure 2 of 3 residents received medications as prescribed (Resident #1 and #2). Resident #1 had a prescription for Ipratropium .02% administered three times a day. The facility failed to ensure the prescription was available. Interview with Resident #1 revealed resident did not receive her morning dose of the medication. Resident #2 was prescribed Celebrex 100 mg BID, the medication administration record (MAR) indicates Resident #2 received 200 mg of Celebrex one time a day. A change order was not on file. This was a repeat deficiency from the 9/10/09 State Licensure survey. Severity: 2 Scope: 3	Y 878 ✓	Resident #1's Ipratropium was delivered 7/8/09 Medication was then given to the resident. P/S. see attached delivery slip on page 4. Resident #2's Celebrex was change back to 100 mg BID 7/17/09 P/S. see attached medication list and prescription copies on pages 5 and 6. DJB 7/20/09 Administrator is responsible that medication should be available for resident to use and any changes in order should be recorded on file will monitor daily for compliance.	
Y 883 SS=D	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.	Y 883		

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Y 883	Continued From Page 4 This RULE: is not met as evidenced by: Based on interview and observation on 7/8/09, the facility failed to ensure the doctor was notified for 1 of 4 residents refusing medications (Resident #2). Resident #2 refused to take Neurontin 100 MG PO TID, Senakot 2 tablets per day, and a multivitamin, the physician was not notified. Severity: 2 Scope: 1	Y 883	Resident #2's Neurontin Prilosec and multivitamin was discontinued by the physician. Senokot was the same. P/s. see attached medication list on page 6. 7/20/09 10/17/09 Administrator is responsible that physician should be notified when resident refuses medications, should be documented will monitor daily to be in compliance.	
Y 885 SS=E	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This RULE: is not met as evidenced by: Based on observation and interview on 7/8/09, the facility failed to destroy medications after they were discontinued, had expired or after a resident had been transferred for 2 of 5	Y 885		

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Y 885	Continued From Page 5 residents. (Discharged Resident #4 and #5). Expired medications for Discharged Resident #4 were found unlocked in the caregivers room. The facility failed to destroy prescription medications for Discharged Resident #5 . This was a repeat deficiency from the 9/10/08 State Licensure survey. Severity: 2 Scope: 2	Y 885 ✓	Resident #4 and #5's expired medications was destroyed and log. Administrator is responsible that when resident is discharged from the facility medications should be destroyed or disposed properly upon discharged of a resident to be in compliance.	7/17/09
Y 920 SS=D	449.2748(1) Medication Storage NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. This RULE: is not met as evidenced by:	Y 920		7/23/09

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Y 920	Continued From Page 6 Based on observation on 7/8/09, the facility failed to keep medications for 1 of 5 residents in a locked area (Resident #5). Unlocked medications for Resident #5 were found in the caregiver's room. Severity: 2 Scope: 1	Y 920	Expired medication of discharge resident #5 was destroyed and log. Administrator is responsible that all medications should be in a locked area will monitor daily to be in compliance.	7/17/09 7/23/09